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Depressive Illness and Navajo Healing

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Depressive Illness and Navajo Healing

What is the experience of Navajo patients in Navajo religious healing who, by the criteria and in the vernacular of contemporary psychiatry, would be diagnosed with the disorder called depression? We ask this question in the context of a double dialogue between psychiatry and anthropology and between these disciplines' academic constructs of illness and those of contemporary Navajos. The dialogue is conducted in the arena of patient narratives, providing a means for observing and explicating processes of therapeutic change in individuals, for illustrating variations in forms of Navajo religious healing sought out by patients demonstrating similar symptoms of distress, and for considering the heuristic utility of psychiatric diagnoses and nomenclature in the conceptualization of illness, recovery, and religious healing. From among the 37 percent of patients participating in the Navajo Healing Project who had a lifetime history of a major depressive illness, three are discussed herein, their selection based on two criteria: (1) all met formal psychiatric diagnostic criteria for a major depressive episode at the time of their healing ceremonies, and (2) together, their experiences illustrate the range of contemporary Navajo religious healing, including Traditional, Native American Church (NAC), and Christian forms. We suggest that, despite the explicit role of the sacred in religious healing interventions available to Navajo patients, differences between biomedical and religious healing systems may be of less significance than their shared existential engagement of problems such as those glossed as depression. [depression, psychiatry, religious healing, narrative, Navajo]

Our goal in this article is to contribute to an understanding of illness experience among Navajos who have participated in the three forms of healing examined in the Navajo Healing Project (Csordas, this issue). We do so in the context of a double dialogue between psychiatry and anthropology (the first author is a psychiatrist) and between these disciplines' academic constructs of illness and those of contemporary Navajos. Central to the first dialogue are the repeated efforts by Western psychiatry to define reliable and valid categories of psychiatric disorder, as evidenced by three updates since 1980 of the American Psychiatric Association's *Diagnostic and Statistical Manual of Psychiatric Disorders*. These efforts have been subject to critique from the standpoint of both anthropology and cultural psychiatry on the grounds that they unduly reify disease categories as biological entities and that their generalization is an ethnocentric imposition of Western categories that suppresses cross-cultural variations in illness (Gaines 1992; Kirmayer 1997; Mezzich et al. 1996; Taussig 1992). In our view, the most productive stance has been expressed by Byron Good (1992), who suggests that along with conceptual critique, psychiatric diagnostic categories be taken seriously by subjecting them to systematic cross-cultural investigation, at the same time critically examining the anthropological hypothesis about the cross-cultural heterogeneity of psychiatric disorder.

Our work in the Navajo Healing Project embraces this approach. Further, while recognizing the limits of dialogue between anthropology and psychiatry, we also recognize anthropology and psychiatry as sister sciences and grant at least heuristic value to psychiatric categories as provisional etic formulations of distress for comparative purposes. This approach is central to the second of our dialogues, that between academic and indigenous understandings of illness experience. However, we do not frame this dialogue as a comparison of "Western" and "indigenous" diagnostic categories as such: in that case the analysis might juxtapose depression and what Navajos recognize as *hochxoo'ji* (illness requiring treatment by the Evilway ceremony), which is frequently associated with the emotional consequences of bereavement. Neither do we offer a comparison of the diagnostic practices of psychiatrists and those of Navajo healers: issues pertaining to Navajo diagnosis are taken up separately in the contribution by Derek Milne and Wilson Howard (this issue). Instead, our method is to ask the following question: what is the experience of Navajo patients in Navajo religious healing who, by the criteria of contemporary psychiatry, would be diagnosed with the disorder called *depression*? Formulated in this way, the dialogue is between those data that allow for a psychiatric research diagnosis and those data that allow for an ethnographic understanding of illness experience.

Our interest in whether depressive symptoms are factors in Navajo patients seeking religious healing originated in part with the observation that depressive disorders are prevalent, though often undetected, in Western medical primary care (Coyne et al. 1994; Wilson et al. 1995). In addition, depression may be an especially salient psychiatric disorder for ethnographic study, given its biological, psychological-existential, and sociocultural determinants. Kleinman and Good (1985), in concluding their essential collection of psychiatric and anthropological essays on depression, ask for cross-cultural research that seeks to (1) address fundamental questions of validity regarding categories of depressive illness, (2) explore the role of emotions and cognitions in depression, (3) discern how somatic

symptoms and anxiety relate to constructs of depression, and (4) characterize the connection among social relationships, power, and the development and maintenance of depression.

The accepted diagnostic coding systems in psychiatry are found in *The International Classification of Diseases—Tenth Edition* (ICD-10) (World Health Organization 1991) and the American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). Both posit that depression, as a discrete illness, is a cross-culturally valid construct. For a diagnosis of depression, both the ICD-10 and DSM-IV require that a patient have low mood and/or loss of major life interests for at least two weeks. An individual must also be experiencing several of the following symptoms: appetite change, sleep cycle change, poor concentration, and fatigue. In the Navajo Healing Project, we used the DSM-IV criteria for depression and other psychiatric disorders (see Figure 1).

The ICD and DSM classification systems both claim to be purely descriptive and "non-etiological" and to advocate no specific treatment strategies. But though there are advantages to trying to make internationally approved diagnostic nomenclature systems lean and reductionistic, there are risks, too. Gary Tucker (1998), himself renowned for explicating biological dimensions of psychiatric illness, regards DSM and ICD manuals as tools for "doing pattern recognition." At the same time, he laments that "the DSM diagnosis has almost become a thing itself—a certainty of 'concrete' dimensions" (1998:159). The diagnostic process can lead, according to Tucker, to the loss of "the patient and his/her story." Even if diagnoses can be reliably and validly obtained cross-culturally, it can be argued that for the healer to be effective, he or she must draw on somatic, psychological, cultural, and historical perspectives obtained from the patient (Engel 1980).

Clinical as well as research inquiry about symptoms may elicit culturally mediated complications from the outset due to several factors. First, some standard lines of questioning about depressive symptoms can be unacceptable in some cultural groups. Robins (1989) notes that Chinese patients, when interviewed about depressive symptoms, are quite reluctant to answer questions about sexual interest. There may be general response biases characteristic of ethnocultural groups, too. For instance, Iwata and associates (1989) found that Japanese patients make efforts to avoid extremes in their answers to diagnostic questions. Second, typical symptom clusters and indigenous labels for them may vary cross-culturally, as Kleinman (1980) has shown in comparing neurasthenia and depression in China and as Manson and associates (1985) have shown in discussing depressive experience among American Indians. Third, culturally distinct patterns of co-morbidity may blur the boundaries between diagnostic categories, as in the case of depression, anxiety, and substance abuse among American Indians and Alaska Natives discussed by contributors to Maser and Dinges 1992.

Standardized clinical research tools have limitations in characterizing psychiatric problems of ethnically diverse peoples but nonetheless have helped illustrate problems faced by American Indians. Shore and colleagues (1987) utilized a structured instrument, the Schedule for Affective Disorders and Schizophrenia-Lifetime Version (SADS-L), to study depressive phenomena across several tribal groups and found special unifying features among American Indians with depression. Perhaps to help demonstrate the possible complementarity of DSM constructs

■ Criteria for Major Depressive Episode

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
 - (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
 - (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
 - (4) insomnia or hypersomnia nearly every day
 - (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
 - (6) fatigue or loss of energy nearly every day
 - (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
 - (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
 - (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B. The symptoms do not meet criteria for a Mixed Episode (see p. 335).
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

FIGURE 1

Criteria for Major Depressive Episode.

(Source: Diagnostic and Statistical Manual of Mental Disorders Fourth Edition. Washington, DC: American Psychiatric Association, 1994, p. 327.)

and patient ascriptions, O'Neill (1993, 1996) utilized structured interviews as well as more open-ended interview techniques to help patients provide narrative summaries of their difficulties. She was able to provide DSM diagnoses while illuminating the personal and social meanings of such problems as depression and substance dependence within a community. Manson (1996) has noted some signs of shift in the "diagnostic culture" of the DSM-IV, which now suggests that mental health providers should consider cultural influences on the phenomenology and experience of such psychiatric disorders as depression. Nevertheless, from an anthropological perspective this is hardly more than a token shift (see the contributions to Kirmayer 1997). Research that integrates qualitative (ethnographic) and quantitative (structured clinical) interview methods can help inform controversies about the nature and prevalence of DSM disorders and how they may have different social meanings in specific communities.

With respect to validity issues for depression, there has been debate about whether depression is best regarded as a disease, a constellation of distress symptoms ("dis-ease"), or both. The strong familial risk for depression and evidence of genetic diatheses for depressive disorders are a bedrock of the disease model, as is the effectiveness of somatic treatments (Whybrow et al. 1984). Carr and Vitaliano (1985) favor a distress rather than disease model for depression, positing that the symptoms are manifestations of a coping response and should not automatically be construed as pathological. Manson (1996) argues that regardless of primary cause, all symptoms, perhaps, especially, depressive symptoms, cannot be regarded or appreciated out of context of the patient's psychosocial matrix. Depressive experiences may even be positively valued by the individual and also be seen as having some value to the community group. Obeyesekere (1985) describes efforts by Sri Lankan Buddhists to derive meaning and transcendence from distress that is only inadequately captured by the categorical notion of depression.

Depression may also hold meaning for individuals regarding the role of emotional processes in the organization and regulation of the self. Schieffelin (1985) describes how emotions such as anger, grief, and depressive experiences are tied to effective negotiation of social expectation within a community. Emotional states and emotion regulation are posited by Jenkins and associates (1991) to be the integration of bodily experiences, social forces, and communication demands for the individual. Nesse (2000) discusses evidence that depression and its characteristics of pessimism and lack of motivation, rather than being purely pathological and dysfunctional, may have an adaptive function in certain circumstances, such as when a person is faced with an unreachable goal or has insufficient internal resources to allow action without damage. So it could be proposed that regardless of the origin of depressive states, as individuals experience a depressive illness, they may acquire useful new vantage points vis-à-vis themselves and their roles in their social matrix.

In psychiatry, the last decade has seen rapid growth in pharmacological interventions to address Western constructs/medicalized symptoms of depression. The utilization of such therapies has helped advance the notion that depression is a discrete and biologic pathological process in an individual's life. Placing religious healing practices such as those of the Navajo alongside these biomedical interventions can help advance the alternative notion that depression is also a multi-plex social process in intersubjective (community) life. If depression is a complex

intertwining of biological, existential, and social processes, then healing practices that address these dimensions may be especially salient for psychiatric and anthropological investigators. Accordingly, we offer our ethnographic evaluations of Navajo patients and their experiences in a non-Western healing system to the discussion of depression.

Studying Navajo Illness Experience

The Navajo population was less than 7,000 in 1868 after the people barely survived removal from ancestral lands during the U.S. government's campaigns against the Indian tribes of the American West following the Civil War. However, the Navajo proved remarkably resilient, and the contemporary Navajo reservation, a 25,000-square-mile region of high desert and mountain forests centered in the Four Corners region of the United States, is home to nearly 200,000 Navajo people. A central feature of modern Navajo life is the availability of multiple healing systems. The first hospitals on the Navajo reservation were established around 1900 (Kunitz 1983). Today, there are six Indian Health Service hospitals and numerous clinics regionally located near Navajo population centers that together provide a full range of medical services. Overall Navajo morbidity and mortality rates for many health indicators have come to closely approximate the U.S. averages. Some notable exceptions at present are the continued high rates of diabetes, tuberculosis, and serious injuries. Navajos have lower rates of such illnesses as most cancers and HIV infection (U.S. Indian Health Service 1997). Meanwhile, Traditional Navajo healing, provided by a medicine man or medicine woman, has continued to serve a major health care role for Navajos. The Traditional diagnostician determines a patient's disease and disharmony through conversation and hand-trembling or crystal-gazing techniques. He or she then typically refers the patient to a chanter (*hataali*) who performs or coordinates the performance of intricate ceremonial chants, prayers, dances, and sandpaintings to address the dysfunction or distress that brought the patient to the healer. In the last half century, the NAC and Christian religious healing systems have also become essential providers of healing interventions for Navajos. NAC healing is derived from Plains Indian spirituality and centers on a ceremony characterized by ingestion of sacramental peyote and night-long prayer and singing coordinated by the road man (healer), with the patient and his or her family seated around an earthen fireplace. Navajo Christian faith healing, usually based in communal prayer groups, weekly church services, or seasonal revival meetings, has been provided by Navajo Pentecostal ministers for decades. There appears to be an increasing prominence in Navajoland of religious healing by other Christian denominations, too.

Hospitals and clinics may be perceived by Navajo patients as intimidating or unsettling environments compared to the ceremonially prepared hogan for Traditional healing, the tipi for the NAC meeting, or the church or revival tent for Christian services. Especially when experienced in a Western hospital, illness may threaten a Navajo patient and his or her family in ways that cannot be ameliorated by the Western healing system alone (Griffin-Pierce 1997). Hence, many patients and families utilize both medical and Traditional/religious healing systems. In our study, we found that religious healers, alongside Western medical providers, have helped patients cope with the major public health threats faced by Navajo families

in the last half century. Most of the patients in our study had, on multiple occasions in their lives, turned to religious healing to address a wide variety of symptoms and such major illnesses as tuberculosis, diabetes, cancer, ulcers, infant diarrhea, and psychosocially mediated health problems including stress disorders, depression, and substance use disorders. Though mental health services are offered at all Indian Health Service sites, religious healing also provides a primary care resource to patients to address problems often conceptualized in Western medical traditions as emotional or psychiatric in nature (Navajo Health Systems Agency 1985).

In the Navajo Healing Project, four teams, each consisting of an ethnographer and an interpreter, were assigned to the four quadrants of the Navajo reservation. Their goal was to enlist healers (representing Traditional, NAC, and Christian practices) as participants in an ethnography of the practice of religious healing. Healers who agreed to participate in the study were interviewed regarding their healing methods and explanatory constructs related to illness/distress and healing. Patients were typically approached to join the study by the ethnographic team after being recommended for participation by their healers. Other patients were referred by fellow patients or recruited through social networks of the project staff. The majority of patients in the study sought healing for symptoms not directly classifiable as psychiatric. Patient concerns upon referral to a religious healer included such illnesses as gastrointestinal disease, cancer, diabetes, renal failure, heart disease, dermatological symptoms, and dizziness. For this study, Western medical healers were not contacted, and patient medical records were not reviewed.

For each patient, a psychiatric interview was completed after the religious healing interventions and after the ethnographer and interpreter had interviewed patients in detail about their life history, current illnesses, and healing experiences, and had observed an event of ritual healing conducted for the patient (Csordas, this issue). Many of the patients were monolingual Navajo speakers, and approximately half of the interviews were conducted with the assistance of a Navajo language interpreter. The ethnographic team occasionally attended the psychiatric interview to help provide contextual information and, in some cases, to facilitate patient comfort. Transcripts from the ethnographic interviews were not available until after the psychiatric interview.

Psychiatric interviews were conducted by a psychiatrist or psychologist, using the Structured Clinical Interview for DSM (SCID) (Spitzer et al. 1992). The SCID is a semistructured interview for making diagnoses from the catalog of psychiatric disorders as defined by the American Psychiatric Association (APA). The interview consists of an open-ended, information-gathering component (which is used to elicit a lifeline narrative) and separate, algorithmically structured modules exploring mood, thought, anxiety, and substance use disorder symptoms across the patient's life span. We used the SCID-NP, an interview format specifically for nonpsychiatric patients. The SCID facilitates assessing patients across four of the five dimensions (axes) of psychiatric clinical status:

Axis I—primary psychiatric disorders

Axis III—relevant medical disorders

Axis IV—severity of psychosocial stressors¹

Axis V—level of adaptive functioning (can receive a score of 1–100)²

SCID questions do not address developmental and personality disorders (Axis II).

The SCID is seen by its designers as a tool for eliciting psychiatric diagnoses and generally is not used to provide descriptive, qualitative, or narrative information about patient functioning. In our study, the SCID interview took from one to four hours to complete depending on language and patient history factors. In the midst of the SCID interview, we also asked patients how they understood their illness and their religious healing interventions.³

In the first phase of The Navajo Healing Project, ethnographic interviews were conducted with 95 religious healers from among the three systems. Religious healers were asked by the ethnographic team to offer perspectives on methods of practice and the nature of illness-healing. These findings will be presented in subsequent publications. Eighty-four patients, with the permission of their religious healers, elected to participate in the ethnographic interviews, sharing their life and illness histories and their beliefs relevant to their religious healing interventions. At the time of the ethnographic interviews, 33 of the 84 patients were involved primarily with Traditional healing ceremonies, 21 with NAC meetings, and 30 with Christian healing ceremonies. SCID interviews were successfully completed with 79 of 84 patients. Two patients dropped out of the ethnographic study before completion, two patients declined the SCID interview after completing the ethnographic interviews, and one patient died in a motor vehicle accident. The SCID findings will be presented comprehensively in a future publication.

Demographic characteristics of the patients are reported in the tables included in the introduction to this issue, but for convenience can be summarized as follows: 60 percent of the patients were female, and 60 percent of the patients were married at the time of the interview. Patients ranged in age from 16 to 84 years, with nearly half (49 percent) age 50 or above. The Navajo population as a whole is younger than the United States, with a median age of less than 25 years (U.S. Indian Health Service 1997). Our population reflected a substantial diversity of educational experience, with 30 percent of patients completing less than six years of formal education and 27 percent completing more than two years of college work. Over a third (38 percent) of the patients spoke only the Navajo language during the interviews, with another 10 percent speaking both Navajo and English.⁴

Only 22 percent of the patients in our study had no history of a psychiatric disorder per SCID criteria. Thirty-seven percent of the patients had a history of a major depressive illness in their lifetime.⁵ Thirty-four percent had lifetime occurrences of anxiety disorders (primarily post-traumatic stress disorder). Forty-five percent had lifetime histories of substance use disorders (primarily alcohol related). Twenty percent of our patients had lifetime histories of depressive, anxiety, and substance use disorders. We found that 25 percent of the patients in the Christian healing group had a lifetime history of a depressive illness. Forty-two percent of the Traditional and 45 percent of the NAC patients had histories of depression.

Sixteen patients (19 percent) had significant depressive symptoms at the time of their religious healing intervention, which in some cases preceded the SCID by three to six months. Depressive symptoms had remitted for seven of the 16 patients between the time of their healing ceremony and their SCID interview. The prevalences of current disorders at the time of SCID interview were 11 percent for depressive disorders, 10 percent for anxiety disorders, and 5 percent for substance use disorders.

Narratives of Illness and Healing

We discuss three patients selected on the basis of two criteria: (1) all met DSM criteria for a major depressive episode at the time of their healing ceremonies; and (2) together, their experiences illustrate the broadest range of treatment across the three forms of religious healing. We use these case studies to help exemplify the nexus of culture, psychiatric illness, and healing interventions. Information from ethnographic and SCID interviews is then combined to present patient life stories, family traditions, and illness and healing system experiences. We explore each patient's attributions related to his or her symptoms and healing interventions.

Patient #1—Eleanor W.

Eleanor W. is a 64-year-old married woman who is the mother of ten children and grandmother of 35 children. She is the oldest child of a renowned Traditional medicine man. She is highly regarded in her community and outside the Navajo Nation for her rug-weaving skills (as are several of her daughters). She grew up near her current home and had no formal schooling. She tended family livestock as a teenager until she married her current husband at age 17. Her husband is a Traditional healer (a Blessingway chanter). He is also a road man (ceremony leader) in the NAC. Eleanor is a monolingual Navajo speaker. A Navajo-English interpreter facilitated all interviews.

In both the ethnographic and SCID interviews, Eleanor shared many recollections from her childhood. Since she is the daughter of a Traditional healer, she has sought to understand her illness symptoms in Traditional ways throughout her life. She spoke with pride and satisfaction as she reviewed her life. She believed that she developed a strong and resilient spirit as a child and gave credit to the practices she was taught. She recalled being awakened by her parents early in the morning and being sent outside to run. Even in cold weather, she and her younger siblings were required to jump into water or snow to wash themselves. She felt this ritual played a protective role in preventing coughs and colds and lamented that children raised today seem more susceptible to illnesses because they do not have the same rigorous morning habits. Eleanor also recalled learning about loss at an early age. As an eight year old, she was caught in a storm with a cousin and swept down a collapsing sandbank. Her cousin did not survive.

Eleanor noted that she and her family had been active in the Christian Church when she was a young woman, though she had not been active for years. She has participated in Traditional healing interventions and helped with Traditional ceremonies throughout her life. She and her family also have long been members of the NAC. She shared her view that there is significant overlap in Traditional and NAC healing practices.

In addition, Eleanor described lifelong participation in the Western medical system. She lamented that doctors in past decades seemed to have a better understanding of patients' illnesses than they do now. She reported, with apparent pride, that Traditional and NAC interventions had positive effects on her medical problems. At the time of the SCID interview, she was receiving medical treatment for diabetes mellitus, arthritis, and high blood pressure. She also credited her family's knowledge of medicinal herbs as helping to provide symptomatic relief for these

problems. She shared her belief that diabetes is a problem that was not experienced by her elders and, thus, that it was probably caused by contact with “Anglos” and Anglo lifestyle and dietary influences. Eleanor noted that she and her family still seek treatment in the Western medical system, though she has never been referred to a mental health provider. She also noted that her husband is asked from time to time to visit patients in the hospital and provide Traditional healing interventions to augment the Western care.

Eleanor agreed to join this study after a Traditional Navajo diagnostician recommended that she participate in a Traditional Shootingway ceremony. The nine-day ceremony (her first major ceremony in 30 years) involved herb-induced sweating and emesis, intensive healer-led singing, sandpainting, and ceremonial dancing to address knee pain, numbness in her feet, burning in her stomach, dizziness, sleep problems, and difficulty concentrating on her work as a weaver and caretaker of her grandchildren. During the ceremony she learned that her symptoms were due to an accumulation of disharmony and distress related to multiple life events. She was told she had been exposed to risk in utero when she had been too close to her father as he led ceremonial healing. Also, she had eaten corn that had been struck by lightning and a sheep that had been bitten by a venomous snake, and as a child she had been “hit by a rainbow.” She explained that her family had seen her engulfed by the end of a rainbow. She felt this could have been a positive influence for her but still needed to be addressed in her ceremony to help restore the healing effects that a rainbow can engender. She was told during the ceremony that a rainbow could also affect the soles of the feet, causing problems like arthritis. Of the ceremony, Eleanor commented, “It helped me remember compassion for my body because I walk in it. It helps me live and I want to walk in beauty.” During the SCID interview, Eleanor reported that the ceremony brought relief of her arthritic, gastrointestinal, and sleep problems.

The ethnographic field team met with Eleanor several months after her Traditional ceremony. The team had learned in the interim that Eleanor’s father had died. After her father’s death, she experienced the rapid onset of disabling grief and a near complete abandonment of her roles within her family. Eleanor explained to the field team that in her grief she was restless and moved around to the homes of her children to try to escape her distress. “I stayed with them at each place. I couldn’t get comfortable anywhere. I would think maybe if I sat down in a flat area and let the wind blow dirt around me I would feel better. I couldn’t handle it. I lost interest in everything.” The profound distress continued for nearly three months. Then, at the request of her brother (who was worried about her withdrawal from the family), she participated in an NAC ceremony lasting from Easter eve into Easter morning. Eleanor’s family was mindful of the spiritual meaning, from the Christian perspective, of the timing of this ceremony. She reported this effected a significant change in her mind: “I attended the meeting and cried my heart out for my late father. I felt like something was crushing my chest and that it was wrapped all around my chest as hard as you could tighten it, but at this meeting the tightness softened up and then I settled down and that is how I am today.”

The SCID interview took place eight months after the Shootingway ceremony, five months after Eleanor’s father died, and two months after the Easter-time NAC meeting. The following lifetime and current DSM diagnoses were obtained and relevant healing systems identified:

DSM Diagnoses

Axis I. Major depression, in early remission

Agoraphobia, without panic disorder

Axis II. No diagnosis

Axis III. Non-insulin-dependent diabetes mellitus

Axis IV. Moderate to severe psychosocial stressors in previous six months related to health concerns and death of father

Axis V. Global Assessment of Functioning: 85 (good functioning)

Primary Healing System Related to Depressive Symptoms

NAC

Other Healing Systems

Traditional, Western medicine

Eleanor reported no history of psychiatric disorders until the months preceding her father's death, when she developed significant symptoms of agoraphobia (fear of being alone, fear of being away from home). She understood her fear of solitude as relating to her worry over the decline in her abilities. She continued to have symptoms of agoraphobia at the time of the SCID interview.

Eleanor had experienced eight of nine features listed in DSM-IV as criteria for a major depressive illness (only five symptoms are required to make the diagnosis). The symptoms lasted three months. DSM-IV stipulates that if depressive symptoms and functional impairment persist two months beyond the loss of a loved one, the bereavement episode should then be regarded as a major depressive episode (see Figure 1; Criterion E). She reported a persistent loss of appetite, energy, concentration, motivation, and outlook. She acknowledged recurrently imagining her own death but did not contemplate taking her life. She commented during the SCID interview that she had "walked the hills" around her home for hours at a time due to a sense of restlessness and anxiety. During this three-month period she spoke aloud to her deceased father, telling him, for example, that "you left us feeling alone down here."

In the SCID interview, Eleanor expressed her appreciation of her brother's and husband's efforts in setting up the Easter-time NAC meeting. During that meeting she saw herself as able to "question the spirits that linger after death and ask them, 'Why do you bother me? You went into the earth. I'm supposed to be living on the earth and in the sky and being healthy.'" During the SCID, though, she lamented not yet having fully returned to her former energy and vigor. She was worried that she was progressively losing her strength. This was a particularly troubling thought, given her commitment to weaving projects and her sense of responsibility to her children and grandchildren.

There were ample signs during the SCID interview of Eleanor's recovery from her bereavement and depressive illness. She used her hands in an expressive fashion to help illustrate somatic and spiritual struggles during the three months following her father's death. She smiled broadly as she discussed her excitement at recovering much of her energy and interest in life again. She described the importance of again being able to spiritedly walk among the hills around her home as she had throughout her childhood and adult years.

Eleanor also noted that during her periods of deepest sadness she tried to improve her low appetite by drinking a lot of water and eating oranges. When she lay down on the ground and contemplated dying, she felt reminded of special powers

she felt she had acquired through years of helping her husband and her father with ceremonies. She explained her despondency as an inevitable existential struggle following the loss of a beloved parent. When asked during the SCID if she had been bothered by thoughts that did not make any sense, she explained, "When relatives are lost or people die the dead spirits always know how to get back to the people that are still alive." She noted that her NAC ceremony had given her the strength to speak out against the "spirits" that had come back to haunt her during her time of loss. Eleanor shared her sense of pleasure that she has been able to resume caring for her nearly 80-year-old mother and regain most of her other roles as the oldest child in the family. At the end of the SCID interview, she showed the interviewers a 5x7-foot rug that she had resumed weaving. Navajo weaving is a highly skilled and labor-intensive traditional activity, and her resumption of the unfinished project signaled re-engagement in a productive life. The rug's intricate designs, for which Navajo weavers from her community are renowned, could not but remind us that to help her through the somatic, psychological, and existential distress of the preceding year she had woven together, to a greater or lesser extent, elements of four healing systems: Traditional, NAC, Christian, and Western biomedical.

Patient #2—Rita T.

Rita T. is a 47-year-old woman who was interviewed in her home, which she shares with three children and two grandchildren. She is fluent in both Navajo and English, though all interviews with the clinical and ethnographic team were conducted in English. Her childhood was marked by separation from her parents for many years. Her mother was diagnosed with tuberculosis when Rita was three years of age and spent six years in a TB sanitarium on the Navajo reservation. Rita was placed in a boarding school for most of her schooling years. She recalled a spartan life, feeling abused in the boarding school and neglected during the summers living with relatives. "It was hard, but I think I learned a lot from all the discipline." She spoke in some detail about specific punishments at the boarding school, including being forced to stand in a closet with several other children all night long. She recalled harsh hygienic interventions such as chemical treatment for head lice that led to chronic sores on her scalp.

Rita married at the age of 19 after becoming pregnant by her boyfriend. Her marriage was marked by her husband's ongoing abusiveness and threats of death, until he himself died 20 years ago from illness. A second marriage ended in divorce prior to her involvement in this study. At the time of the SCID interview, she was working toward a baccalaureate degree and expected to graduate within 12 to 18 months. Rita reported that she had gotten closer to her father and her mother in the last decade and derived a good deal of support from them, particularly from her father, who is a Traditional healer.

Rita was diagnosed with cancer just prior to her divorce. She regarded this as "the shock of my life." Though she regarded the surgical and chemotherapeutic interventions as successful, she was left with some physical limitations. For example, she was less able than she had been to tend the family livestock. At the time of the SCID interview, she reported that her cancer was in remission and that she was pleased with her extensive medical care. She joked at one point, "The doctor told me that my records are about as big as the Old and New Testament."

Rita was raised in the Traditional Navajo healing system. Her second husband, though, had been quite active in the NAC. She regarded this as a source of conflict, given her Traditional values. She also noted that her cancer doctor had expressed his concern about the possible negative influences of peyote (used in NAC ceremonies) on her cancer treatment. In the midst of her quandary regarding NAC versus Western healing interventions, she began to spend time with an elder in the community who introduced her to a Christian prayer group. Her Christian friend encouraged her to join Pentecostal prayer services but was also supportive of Rita having a Traditional Navajo Blessingway ceremony to help her through the cancer treatment. The same friend was quite opposed to Rita staying active in the NAC. Rita's husband left her soon after she was diagnosed with cancer.

At the time of the SCID interview, Rita was involved with her Christian prayer group several times a week. She was actively raising grandchildren in her home, working outside the home, and enrolled in upper-level baccalaureate coursework. She was continuing medical follow-up for her cancer. She shared with the interview teams that she could not yet regard herself as a cancer survivor. She understood that she needed to be free of the cancer for five years before she could call herself a survivor. The following lifetime and current DSM diagnoses were obtained and relevant healing traditions identified:

DSM Diagnoses

Axis I. Major depression, current, moderate

Alcohol abuse, sustained remission

(subthreshold: Post-traumatic stress disorder features)

Axis II. No diagnosis

Axis III. Carcinoma, possibly remitted

Axis IV. Moderate to severe psychosocial stressors related to parent, grandparent responsibilities, health concerns, and abuse exposure

Axis V. Global Assessment of Functioning: 68 (symptoms cause mild impairment)

Primary Healing System Related to Depressive Symptoms

Christian

Other Healing Systems

Western, Traditional

Rita's lifetime psychiatric history is remarkable for her having had intense symptoms of posttraumatic stress disorder (PTSD) during much of her first marriage. Her hypervigilance, nightmares and flashbacks of the abuse, and nihilistic outlook on life at that time might better have been construed, though, as a protective response to ongoing trauma. Rita reported being beaten by her husband during her first pregnancy. "I couldn't fight back, if I opened my mouth I'd get hit." Rita acknowledged symptoms of alcohol abuse during her first marriage. She reported resorting to drinking with her husband because she couldn't get him to stop abusing her. "I was a punching bag for him." She recalled that their fighting intensified due to her drinking and that at one point she attempted to attack him. "After that, I stopped drinking." Her PTSD symptoms largely remitted soon after the loss of her first husband.

Rita reported four periods in her life when she experienced symptoms of major depression for at least two weeks. Two occurred after the diagnosis of cancer. She recalled "being down and depressed and crying a lot" and also being unable to

eat, think, or get out of bed in the wake of her husband's departure. She consulted a social worker and met with a psychiatrist for several sessions, and found this helpful "for a short time." As stated above, she also credited her father and her Christian friends with helping her endure her stresses. Nonetheless, she had felt sad, lonely, and anxious for much of the two years following the diagnosis. She also reported a resurgence of post-traumatic stress symptoms in the form of flashbacks to the violence of 20 years ago. She acknowledged trying to "fight off" chronic depressive feelings by focusing on the needs of her children and grandchildren. She tried to see herself as "a different person" as she struggled to get through her cancer and to earn a bachelor's degree.

At the time of the SCID interview, Rita endorsed seven of nine criteria for an episode of major depression, which, for her, included having "burned-out feelings," low mood, loss of interest, weight loss, insomnia, agitation, and difficulty concentrating. However, she denied having any suicidal ideation or feelings of self-reproach or worthlessness. Rita had not sought any medical or psychiatric treatment for her depressive feelings and also noted that she had not requested help specifically for depressive feelings from her minister.

Rita reported that she had been encouraged to have a prayer meeting in the weeks preceding the SCID interview. "I needed help to let things go smoothly and I put that request out for a prayer meeting because I really needed help in school. I was really burned out. I had headaches and body aches and I guess my body knows I was really putting a lot of pressure on myself." She referred to her healing through the Pentecostal Church as something that brought a sense of belonging to and acceptance by her community. "God's word is healing, and the most powerful word is love. The church people are here to love. The healing power has brought me inner power deep inside, and I know that God has healed me, the cancer is healing, and even though there is still emotional pain, I know I am strong enough to keep going." She regarded herself as "a newborn child of the Lord still trying to find myself, trying to climb the stepladder."

When asked how her minister would explain the health effects of her faith, Rita stated, "He would say that through prayers the Word comes to you and you learn that the Lord cares for you. The Lord knows you're suffering . . . and can bring you salvation. . . . I used to be greedy and mean and selfish and now I've changed. Now I can reach out." She shared with the ethnographic team her experience of conversion to Christianity (two years before the SCID interview). "When I went to church it was with a heavy load on my back, but when I walked out I felt real light like I was walking on the clouds. When I got saved I had to say my own prayer from my heart, from my inner self to just give everything, all my problems back to the Lord and let Him take care of it." The idea that through prayer she could gain relief and lighten her burdens seemed to be a central healing theme for her. Rita shared no sense of conflict about having three healing systems (Traditional, Christian, and Western medical) contributing to her care.

Patient #3—Jimmy Y.

Jimmy Y. is a 62-year-old married man, father of three children, grandfather of nine, and great-grandfather of one. He is one of seven children, and his mother lives in a nursing home in a nearby village. Jimmy had no formal school education.

He has retired from full-time carpentry work but continues to be active, as he has been for 40 years, as a leader of ceremonies in the NAC. From Jimmy's home one of the four sacred Navajo mountains is visible 40 miles away. His wife Helen was present for most of the ethnographic and SCID interviews. She often offered supportive and clarifying comments. Both Jimmy and Helen are monolingual Navajo speakers, and a Navajo-English interpreter therefore facilitated all interviews.

As a child, Jimmy was raised to tend to his family's livestock. His father died when he was young. He recalled learning from his mother and grandmother to appreciate the needs of others. His grandfather introduced him to Traditional Navajo principles of healing. He began to integrate NAC practices with Navajo healing practices as a young adult. Jimmy's wife was chosen for him by family elders when he was a teenager. He recalled not fully appreciating Helen as a companion until they had raised several children together. He acknowledged long-standing stresses within his extended family related to issues of jealousy between family and community members. Individuals seeking NAC healing have often brought problems related to jealousy to Jimmy and Helen for their help.

Over the years, Jimmy had been treated by Western medical providers for such problems as skin rashes, fainting spells, an episode of facial paralysis, and for diabetes mellitus. Though he has continued to get medical care in a nearby clinic, Jimmy expressed disgruntlement with Western medicine: "You don't often see the same (Western) doctors, so they don't know who you are. When you see a medicine man you see the same one. The medicine man really gets to know what's going on with you." He credited Traditional healing with helping his diabetes. "Anyone with diabetes needs a Snake Bite Way. Now that I've had all these ceremonies done my diabetes is much better, I don't have to do shots anymore."

Jimmy reported seeking Traditional healing in the weeks preceding his SCID interview to address problems with weakness, fainting spells, skin rashes, and because he was feeling "worn out." He reported, and his wife strongly concurred, that his role as an NAC healer put him at risk for these illnesses as he tried to help others with their problems.

Jimmy had a protection/shield Traditional Navajo prayer ceremony performed for him two and a half weeks before the SCID interview. His family had come to believe that his symptoms were signals that someone was wishing him harm. He noted that the medicine man correctly divined that his vehicle had been sabotaged by those who wished him ill. He had felt similarly at-risk in previous years and sought similar help from the Traditional healer.

During the SCID interview, the following DSM diagnoses were obtained and relevant healing systems identified:

DSM Diagnoses

Axis I. Major depression, current, mild

Axis II. No diagnosis

Axis III. Diabetes mellitus, non-insulin dependent

Axis IV. Mild to moderate psychosocial stressors related to health difficulties and family pressures

Axis V. Global Assessment of Functioning: 75 (symptoms associated with slight impairment)

Primary Healing System Related to Depressive Symptoms

Traditional

Other Healing Systems

NAC, Western

For the month preceding his Traditional ceremony and continuing to the time of the SCID interview, Jimmy endorsed six of the nine DSM criteria for depression, including low mood most of the day for most of the month, disturbed sleep with hypersomnia, restlessness observable by others, chronic fatigue, ruminations about wrongdoing, and significant problems with concentration. Jimmy did not endorse the more classically cognitive symptoms of despondency or feelings of worthlessness but found himself wondering where he had gone wrong and what caused his sadness. He and his wife concluded that witchcraft, jealousy, and family stresses were likely the causes for his distress and physical problems. He reported "feeling worn out" from being a healer: He regarded himself as having been limited in his ability to function as a father and a healer during the preceding month.

Jimmy had no previous history of major depressive or other psychiatric symptoms other than fleeting periods of feeling stressed. Once during the last few years he had turned to alcohol consumption. He recalled at that time feeling under great work and family pressure and drank heavily for several days. The medicine man believed he'd started drinking because he had been "witched."

Jimmy and Helen discussed the specific intervention provided by the medicine man in the preceding month to address Jimmy's distress. It was a "protection ceremony" wherein the family's possessions were blessed, including their house, furnishings, automobile, livestock, and their NAC ceremonial tools (feathers, herbs, stones). According to Jimmy, the ceremony addressed "contagion" issues: "When we perform a ceremony we get in the way of whatever problem the person may be having. If we do a ceremony for him, we will end up getting involved with his problems." Jimmy also noted, "If you experience painful hurts with your physical body, through that you will be able to understand the problems of your patients." Speaking as a healer, and discussing jealousy as a causal factor in his distress, Jimmy stated, "It [jealousy] is like a disease, that's what they call heart-mind-ache." In the ceremony, Jimmy and his wife both received prayers from the medicine man. Prayers were directed by the medicine man toward certain deities (the "Holy People" in Navajo cosmology) and reportedly also targeted the jealous parties.

Helen reminded Jimmy (and the interview team) that he must recurrently attend to the stresses he faced as a healer: "If you do four overnight sings [NAC ceremonies] in a row then you will have to have one overnight sing for you." Jimmy noted that if a person becomes a patient in the correct Traditional ceremony, then the problem (his symptoms) goes away "by itself" in accordance with "the Holy Beings." "It's really sacred, so I think of it in a beautiful way and I will be healed by it and everything will (then) be back in harmony: my children, my wife, even my car, and then I will continue to live on in harmony." Jimmy's specific healing ceremony involved arranging arrowheads on the ground and pointing them outward to help protect him from those who wished him ill. Jimmy recalled that he became exhausted during the ceremony and was told by the medicine man to rest for four days "of reverence" before beginning to be active again. He acknowledged

that the rest period was very helpful for him. "During this time you watch to see if your mind is becoming at ease . . . little by little it goes away . . . all of the sudden you realize that you feel fine, that's how it works."

Jimmy and his wife work together in the NAC ceremonies and thus share risks of contagion from the problems they help others address. They commented that their stress problems (largely experienced as physical symptoms) can go back and forth between them. If one gets better, the other gets sick. When they spoke during the SCID interview, they were hopeful that their strong connection and their persistence would get them through his problems. During the SCID interview, when asked to speak about the best times in his life, Jimmy stated, "My wife and I have been together supporting each other through illnesses. We've gone through the tunnel and overcome turmoil and tribulations. We have come up against all these obstacles, sometimes suddenly, but come out of the tunnel. It's like we've made it into a beautiful place or a beautiful pasture."

Jimmy demonstrated a persistent effort in his interviews to anchor his distress in his own experience as a healer. He seemed almost to welcome distress or at least to see illness as, in part, an opportunity.

When you are a person who performs all these ceremonies for people, you become aware of the entire area of illness, being sick that is part of your treatment. You're totally exposed to everything that affects people. I think that is how you get sick. Every time you get sick you are made aware of what it means to be sick or be well. You then use this experience in your treatment of people. You use certain herbs or certain ceremonies to overcome these illnesses and in turn you have added knowledge how curing and healing is possible through the use of herbs and ceremonies. It's like you gain for your patient. You study how being sick can affect people. You have actual practical experience to help your patients and help you treat them, that's how I look at it.

Experience, Diagnosis, and Therapeutic Change

The Navajo people are renowned for their belief in the integration of physical, mental, and spiritual functioning (Farella 1984; Griffin-Pierce 1992; Lamphere 1977; Levy 1998; Witherspoon 1977). For centuries Navajos have turned to Traditional ceremonies to treat symptoms of disease, distress, and social disjunction. A half century ago, Frank Waters observed the work of the surgeon Dr. Clarence Salsbury, who had provided health care for Navajos for many years. Dr. Salsbury understood that for Navajos "health and religion are inseparably tied up" (Waters 1950:386). In the last five decades, the strong link, for Navajo people, between health care and spiritual path (living in harmony) has provided a fertile medium for the sustenance and growth of three major religious healing systems (Traditional, NAC, and Christian) that complement Western medical care.

The patient stories presented here are intended to show that patient ascriptions of illness and healing expressed in religious forms can provide a means for observing and explicating some processes of therapeutic change in individuals, and to illustrate experiential processes in Navajo religious healing for patients demonstrating (by Western psychiatric constructs) similar symptoms of distress. We have not sought to assess the validity of the diagnostic categories, the nature of the diagnostic process, or the efficacy of the interventions but, instead, to characterize the

experience of making use of the three healing systems. Our findings are not meant to suggest that Navajo patients are especially prone to depression or psychiatric disturbances but, instead, to describe how they understand, experience, and come to terms with problems that would be categorized as depression according to psychiatric criteria. We are aware, too, that the patients in this study may not be representative of all groups of Navajo individuals who might meet criteria for depression. Our patient group may represent (as evidenced by their willingness to participate in many hours of ethnographic and clinical interviews) a more expressive, optimistic, and socioculturally secure group than many others experiencing depressive illnesses. None of the three patients discussed here was seen as suffering from cultural alienation, at least during the period of our study.

We entered the study with some apprehension about how Navajo patients would experience the Structured Clinical Interview for DSM-IV (SCID). Given concerns about the palatability of a lengthy structured psychiatric interview process (especially when translation was necessary), we were appreciative of and dependent upon patient and interpreter patience in completing all the modules of the SCID.

Though ethnographic and psychiatric interviews may be time-consuming for patients, we have not assumed that research interviews are necessarily aversive. We noted that many patients seemed to be reflective and curious, and some expressed appreciation for the opportunity to review their lives. Scarvalone et al. (1996) observed in their study of HIV patients that many individuals reported a diminishment in feelings of distress by participating in a SCID interview. At the end of their SCID interviews, many Navajo patients in our study offered their hope that their answers would help Western doctors (such as the SCID interviewer) and traditional and religious healers learn from each other.

Our inquiry has taken us into the heart of questions about the concepts and constructs of depression. For the three patients presented here, the SCID interview discerned symptom clusters that depicted discrete distress experiences associated with arguably similar cognitive and somatic difficulties and impairment in social and occupational functioning. All three patients endorsed six or more of the nine symptoms constituting a fundamental DSM diagnostic criterion for a major depression (at least five are required to meet the criterion). All three acknowledged sustained sadness, self-doubt, and pervasive loss of interest in important life activities prior to their religious healing ceremonies. Each patient identified him or herself as unable to adequately perform his or her social and family duties during the distress. Though the *Diagnostic and Statistical Manual* for DSM-IV does not require or stipulate that specific biological or psychosocial factors are causal or necessarily contributory for a diagnosis of depression, our patients each identified factors they felt generated their symptoms. These factors, though in part somatically manifested, seemed to emanate from the patient's psychosocial milieu.

Our patients' distress experiences were socially monitored if not mediated. Family members and/or community supporters were vital in encouraging the patients to seek help. For three months, Eleanor's husband and brother watched her progressively abandon her usual competencies. Noting her enduring inertia, they arranged the NAC meeting. Rita's fellow church members enjoined her to ask for a prayer meeting when she felt herself to be overwhelmed and drifting from her

Christian support group. Jimmy's wife served as his sentry and symptom monitor to detect when he was overdue for a protective intervention.

Neither the patients nor their healers appeared to label the symptom cluster "depression" per se—and there is no reason they should have.⁶ There is no Navajo term that fully corresponds to the English notion. Navajos we interviewed sometimes used *yíníít* to denote that someone is worried, sad, or distraught (see also Young and Morgan 1987:769). A recent dictionary for health care providers glosses depression in two ways. The first is, *doo bá'áts'ída*, or "lonely and sick." The second and more elaborate approximation is *yee'iiná 'íil' íídoígíí dóo yee hodi' áadoígíí bee bich' í nahwii'ná*, roughly, "something is not right that is giving you a problem making a living and taking care of yourself." In the latter phrase, the "something" is implicitly evil. Moreover, subtleties of both vocabulary and phrasing create inevitable ambiguity at the linguistic frontier between English and Navajo (in particular, questions in the Mood Disorder module of the SCID were difficult to translate).⁷ Neither is there a complete concordance between Navajo and psychiatric understandings with respect to what falls within the domain of symptoms—in Navajo experience, a negative event, setback, or obstacle is as "symptomatic" as a pain, depressed affect, or inability to stop drinking.

Though each of these observations in itself points to a methodological issue, their global import can be summarized by saying that Navajo healers treat the patient rather than the disorder, guided by the patient's specific alienation from safety and security. This does not necessarily involve extensive interviewing or elicitation of the patient's narrative, but it often includes ceremonial treatment custom tailored to the patient's needs. Through the religious healers' interventions, the patients come to understand what we call their depressive symptoms as signals. Eleanor perceived her religious ceremony as a guidepost signaling when it was time for her to rejoin her lifelong roles in the family. Rita learned that her distress was a result of taking on her problems alone and forgetting that "the Lord will take care of it." Jimmy's ceremony taught him how to see his symptoms as lessons about stress management and perseverance in the face of ongoing risk. Each patient felt that his or her healer offered personalized interventions that were targeted to his or her own somatic, psychological, and social-existential distress and that helped to re-secure the patient in the community.

The DSM provides a nomenclature for labeling, but most of its diagnostic constructs are specifically avowed to be free of etiologic implications. Furthermore, there are no specific treatment recommendations offered in the manual. If we make a diagnosis of depression, then what have we identified and for what purpose do we identify it? What is the benefit of linking these or any patients with a specific diagnosis?

The "non-etiologic" DSM, because it aspires to neutrality with respect to causation and treatment implications, may allow for less controversial and less socially stigmatizing labeling. On the other hand, the diagnosis, the label, the "stigma," the reductionist process inherent in all healing is a beginning point for the patient transformation. The DSM categorizes "disorders" but does not address the logical implication of using the term *disorder* by suggesting pathways from "disorder" to "order." For Navajo religious healers and their patients, the attributional matrix, grounded in life context and narrative themes, provided the template for change, the direction out of the distress. Presumably, the healers were poised

with their diagnostic knowledge to truly guide the patient from “disorder” or “disharmony” (in Navajo concepts of disease) to improved order or harmony.

The perspectives provided by these three patients demonstrate the interplay between anxiety, somatic distress, cognitions, and social efficacy. It appears that these patients utilized the many facets of their distress as signals to guide them toward the help of the healer. As has often been observed in studies of ritual healing (Bourguignon 1976; Csordas and Kleinman 1996; Csordas and Lewton 1998; Dow 1986; Frank and Frank 1991), through the therapeutic process all three patients seemed to experience a transformed sense of meaning about their symptoms that helped them put their distress, and perhaps their life as a whole, into a richer grid of personal and social meaning. Specifically, each patient was able to reconnect with experiences helpful to him or her earlier in life. Eleanor reaffirmed the value for her of “walking the hills” to gain strength as she had done as a young child. Rita could see that some degree of stoicism (as modeled by the life of Jesus) would help her through her hardships. She had learned in boarding school how to be tough and strong. Jimmy was thankful that he had learned as a newly married teenager how to deal with the personal and family problems caused by jealousy.

Navajo healing, and religious healing in general, has for decades been compared to psychotherapy (Csordas, 1990, 1994; Frank and Frank 1991; Janet 1925; Leighton and Leighton 1941). Indeed, though none of the three patients we have discussed had recourse to Western mental health systems for treatment of the depressive disorder, the three religious healing systems appeared to offer therapeutic strategies similar to such contemporary Western psychotherapeutic modalities as psychodynamic, cognitive-behavioral, and narrative/solution-focused therapy. Each patient was encouraged into a cognitive life-reframing process to recontextualize his or her problems. Jimmy had to reassess his notions of self-vulnerability and figure out how to improve his habits of self-protection. Rita worked to clear old pains and threats from her current relationships, put cancer fears into perspective, and resolve some of her anxieties about re-engagement in the world. Eleanor had perhaps the most profound healing task: reworking her sense of family position following the life-central loss of her father.

For our three patients diagnosed by SCID with a major depressive disorder, the narrative interplay between patient and healer gave rise to apparently useful constructs of causation. The religious healing system constructs and patient symptoms and attributional notions were meshed by the healers to yield contextually derived solutions and healing paths to help guide the patient out of distress. Thus, common elements in the experiences for our three patients (beyond their meeting DSM diagnostic criteria for depression) were that (1) their “idiom of distress” was recognizable by their healer, (2) somatic, cognitive, and spiritual issues were seen as interrelated, (3) their illness/distress was linked to variables in their life stories, (4) their tools for regaining health/harmony/grace were latent within them, (5) their problems were addressed in a personalized fashion, and (6) healing was facilitated in a community/family context. These considerations suggest that if there is a distinctively Navajo pattern of depression, it does not consist only of a constellation of depressive symptoms somewhat different from that typical among non-Navajos, but also of cultural attributions and interpretations of depressing life situations and cultural patterns of reordering and reintegrating the lives of distressed people.

Conclusion

All forms of healing are based on a conceptual scheme consistent with the patient's assumptive world. The scheme prescribes a set of activities and helps sufferers make sense out of inchoate feelings, thereby heightening their sense of mastery. [Frank and Frank 1991]

We have predicated the preceding discussion of Navajo illness experience on understanding depression as an etic category of distress conceptualization, derived from the Western psychiatric diagnostic method, that endeavors to validate the clustering of symptoms for the purpose of comparing patients' functioning. The *Diagnostic and Statistical Manual* was born in the post-World War II era as a classification system to collect statistical information. The DSM-I, published in 1952, recognized the role of multidimensional circumstance in determining diagnoses. "The use of the term *reaction* throughout DSM-I reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented the reactions of the personality to psychological, social, and biological factors" (American Psychiatric Association 1994:xvii). Thus, historically, the DSM is rooted in the view that context and personal meaning matter in diagnosis (pattern recognition) and conceptualization (formulation) of disorders. Disorders need not and should not be regarded in the absence of etiologic or treatment implications. It has taken a few decades in psychiatric diagnosis for the idea that psychiatric illnesses and existential/contextual factors are inseparably linked to regain prominence. Psychiatrist Gary Tucker concluded his recent appeal to his fellow psychiatrists, "The time has come to merge the empirical psychiatry of DSM-IV with the story and actual observations of the patient. Accurate observation and the story of the patient must be included in our diagnostic processes. All are necessary for the effective care of patients, which, in the long run, is what it is all about" (1998:161). Indeed, our patients faced both similar symptomatic distress experiences, as identified by the SCID, and similarities in their treatment interventions that pointed beyond the heuristic reduction of their diagnosis to a rich matrix of somatic, psychological, sociocultural, and existential-religious variables. Stated in terms of a more general conclusion, the specificity of symptoms expressed in formal diagnosis contributes to our understanding insofar as it is complemented by what Byron Good (1994) calls the subjunctivity or existential open-endedness of experience expressed as narrative.

Diagnosing is a process common to healing systems. Indeed, the etymology of the term *diagnosis* takes us to the Greek prefix *dia-*, meaning "through, between, across" and *gnosis*, meaning "knowledge" or "knowledge of spiritual things, mystical knowledge" (Webster's 1989). The results of the ostensible non-etiologic SCID, as with any diagnostic scheme, including those utilized by Navajo religious healers (see Milne and Howard, this issue), are used to place a patient's distress in a nexus of causal vectors. The healer ideally comprehends the idiom of distress, the somatic and psychological manifestations of disjunction, the metaphors of alienation, and the patient's place on the grid of social-existential connections and guides the patient to a re-secured sense of self-efficacy and reframed sense of purpose and hope. All healers must address complex variables with their treatment strategies and interventions. Medical doctors and traditional religious healers are often referred to in the Navajo language by the same noun: *azee' il 'ini*, which can be

translated "medicine maker." Navajo patients expect *both* kinds of healer to make diagnoses and conduct treatment interventions, to "make medicines" that lead from dis-ease to ease and from dis-order to order, thus delivering them from their specific distress.

As in much of the literature on medical pluralism and ritual healing (Brodwin 1996; Csordas and Garrity 1994; Csordas and Lewton 1998; Leslie 1980; Romanucci-Ross 1969; Rubel 1979), we found that the vast majority of Navajo patients in our study utilized multiple healing systems to address their distress. Though they reported that they were cautious and often reticent in revealing their involvement in one system (for example, a religious healing system) to the healer of another system (such as another religious healer or a Western medical provider), they generally did not regard the systems as mutually exclusive. Many, perhaps most, patients regarded their religious healing involvement as an activity that had served or could have served a complementary and collaborative role with their Western medical care. This observation is especially relevant if these religious healing systems are conceptualized as additional forms of "primary care" to which patients bring problems such as depressive symptoms to the provider for treatment.

In the last decade, the Indian Health Service, a branch of the U.S. Public Health Service, has also come to appreciate the complementarity of healing systems available for American Indian patients. Regarding his agency's commitment to effective collaboration between healers, Dr. Michael Trujillo, Assistant Surgeon General and Director of the Indian Health Service (1994) has offered this statement: "The Indian Health Service (IHS) recognizes the value of traditional beliefs, ceremonies, and practices in the healing of body, mind, and spirit. The IHS encourages a climate of respect and acceptance in which traditional beliefs are honored as a support for purposeful living, and an integral component of the healing process." Despite the explicit role of the sacred in religious healing interventions available to American Indian patients, differences between biomedical and what we have called religious healing systems may be of less significance than their shared existential engagement of problems such as those we gloss as depression.

NOTES

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1. "Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of a mental disorder (Axis I and II)" (American Psychiatric Association American Psychiatric Association 1994:29). Problems are grouped into a range of categories, including those associated with primary support group, social environment, educational, vocational, economic, legal, and health care systems, and so on. Clinicians and researchers rate net severity of psychosocial stressors as none, mild, moderate, severe, or catastrophic.

2. Axis V is for reporting the clinician's or researcher's judgment of the overall psychosocial and occupational functioning of the individual. A score of ten represents grave disability, with 30 representing gross impairment, 50 serious impairment, 70 mild impairment, and 90 or above minimal or no impairment.

3. Our questions included:

- a. Can you tell me what kinds of difficulties you were having that caused you to see a healer? How did you know you were ill?
- b. How do you understand or explain the cause of your illness/difficulties? Do you think there were emotional factors in these difficulties?
- c. Did other people in your family or community know you were sick/ill/having difficulties? What did they say? What did they think was wrong with you?
- d. Did you see a physician, nurse, psychiatrist, mental health worker, substance abuse counselor, minister, road man, medicine man . . . ?
- e. Would you feel comfortable telling me about the healing ceremony that you had?
- f. How do you understand your illness now that you have had a healing ceremony/prayer meeting . . . ?
- g. How would your healer explain your illness or difficulties?

4. These proportions include patients across a wide age range. Although to our knowledge comprehensive figures on monolingualism and bilingualism are not available for the general population of Navajos, it is safe to say that the majority of monolingual English speakers are under age 20 and the majority of monolingual Navajo speakers are over 50. In our experience, it was not uncommon for participants in their forties to choose Navajo as the language for at least a portion of their interview.

5. This is well above the lifetime prevalence for mood disorders discerned in a large sample non-patient epidemiological survey of U.S. households in the early 1980s (Robins et al. 1984).

6. Since two of the patients and two of the healers were monolingual or primary Navajo language speakers, we must explore the translation process in the ethnographic and SCID interviews to discern the specific patient and healer semantics.

7. In subsequent publications, we will discuss the linguistic challenges posed by our interviews, including explicit comparison of ethnographic and diagnostic interviews.

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